PART 3

TREATMENT: ADJUNCTIVE MODULES

Introduction to Part 3: Modules

In the preceding section we have provided a detailed account and clinical examples of how to present the rationale for and to implement the core techniques of CBT for TTM, which include awareness training, stimulus control, competing response training, and maintenance. In our view clinically this package constitutes the foundation upon which TTM treatment should be based, and the available research data attest to the efficacy and durability of this protocol. Nevertheless, the empirical data on TTM in adults suggest that relapse following treatment with CBT protocols containing these elements is not uncommon, and recently clinical researchers have begun to consider adjunctive or alternative approaches to the treatment of this chronic problem. From several recent reviews of this literature it appears that there may be need for affect management strategies to help with pulling behavior that is clearly serving some strong affective function (e.g., Linehan, 1993). From a clinical standpoint it is important to examine with the patient during the early stages of awareness training the degree to which intense emotions (e.g., depression, anger) are linked to urges to pull and pulling behavior. Accordingly, we have included in the manual several modules that we have found useful on a case-by-case basis to help modulate the effects of affect on pulling. These include relaxation training/stress management procedures for patients who report that their TTM is linked to anxiety, stress, and muscle tension, and cognitive restructuring for those whose irrational thinking contributes either directly or indirectly to pulling behavior.

We have also included in this section a module on motivational enhancement – although many of our TTM patients come to treatment ready and willing to "work the

program," others are less intrinsically or extrinsically motivated to reduce pulling behavior. Moreover, even in patients who start treatment with enthusiasm, motivation can wane over time, and thus a module on motivational enhancement struck us as especially important to include with this manual. One of us (DFT) has developed a motivational program based on the work on Motivational Interviewing by Miller and Rollnick (2002) and tailored for use with adult OCD patients who initially refused CBT. An empirical study of that protocol indicated that compared to a control condition, the motivational enhancement program was successful in helping patients re-engage and enter treatment (Maltby & Tolin, 2005). We have tailored our discussion of motivational issues here to address the specific issues that often arise in TTM.

In addition to the modules on relaxation/stress management, cognitive restructuring, and motivational enhancement, we also decided to include two other modules in this section, one on group treatment and other supportive methods, and another on family-based approaches. There is now at least some study of the efficacy of group approaches for TTM in adults, and they may be thought to play an adjunctive role in treatment; one of the primary advantages of group approaches is that they by their very nature allow patients to recognize that they are not the only ones struggling with TTM and related problems. Group treatments can range from those that are designed specifically to teach the same CBT techniques we discuss here to those that are much more focused on providing support for participants; both will be discussed in turn. The development of web-based technologies that allow patients to access information about TTM and its treatment may also be a way to improve access to care – we discuss in that module the program called Stoppulling.com, which was developed for this purpose and now has empirical support for its efficacy (Mouton-Odum et al., 2006).

Family-based approaches certainly make logical sense for younger patients and although they have been advocated they have generally not been subjected to empirical testing; such approaches are imperative when the presenting patient is a toddler or pre-schooler or when negative family interactions about TTM and other matters predicts pulling behavior (Wright et al., 2003). Families of children and adolescents obviously play a critical role in the delivery of even the core modules, and in this section on family factors we will expand on how we try to work with families of children and adolescents across the developmental spectrum; for those who are focusing on treatment of children and adolescents we suggest reading the family section even before delivering the core modules, lest family factors arise in treatment that require specific clinical attention.

We encourage those who have purchased the manual to review the material contained in these as-needed modules to determine whether and how they might be incorporated into the clinical management of clinical patients with TTM that you encounter in clinical practice. For those clinicians who work primarily with children and adolescents, the chapter on family-based approaches might be useful background reading in anticipation of difficulties and clinical decisions to be made in response to emergent family issues.